thorough reading of the article and quite pertinent and cogent comments to which I will respond.

I would agree totally with Dr. Tucker in his feeling that not all staphylococcal empyemas according to his description warrant tube thoracostomy. The exquisite sensitivity of this organism to antibiotic therapy obviates the need for this in many cases. This is especially true for those empyemas which appear as small radiographic fluid collections blunting the costophrenic angle or resulting in blurring of the diaphragm on an upright film. The vast majority of these will respond to antibiotic therapy alone.

However, in those particular infants who are often seen late in their infective course, who are quite toxic and who have a significant empyema with an air fluid level, often the result of a ruptured pneumatocele, we do believe tube thoracostomy is indicated. This particular pattern is uniquely common with the staphylococcal organism in infants where frequently the "pneumonic" phase of the disease is quickly passed through in progression to frank empyema. This is not true in older children and adults. The proper placement of a chest tube by a skilled surgeon under optimal circumstances we feel is the conservative approach and not associated with discomfort. This will often rapidly improve a risky, if not life-threatening, clinical situation, and further, it may greatly shorten the hospital stay. The rapid response in these kinds of infants to tube drainage and antibiotics with virtually no additional morbidity supports this view. These principles also concur with Dr. Tucker's feeling about treating patients and not x-ray films, with which we wholeheartedly agree. I appreciate Dr. Tucker's comments and the opportunity to reply.

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## Community Hospital Continuing Medical Education— A Missed Opportunity

TO THE EDITOR: Community hospital based Continuing Medical Education (CME) activities continue to be a sorely neglected portion of CME efforts. The benefits of such programs when well organized and implemented include: (1) problem-oriented learning, with its educational advantages related to direct physician involvement in local medical problems and personal knowledge of the patient, (2) the flexibility and adaptability of the local teaching programs to local needs, exceeding by far that of the usual "out-of-town" offering by a university medical center, (3) the enormous saving in time for physicians who may attend local CME meetings during their lunch hours as opposed to leaving their office for several days and (4) the substantial monetary savings to practicing physicians, not only by reducing their time away from office, but also by reducing expenses incurred from travel, food and lodging, and rising tuition fees.

Although these benefits are widely acknowledged, the overwhelming amount of educational time, money and energy continue to be channeled into the more traditional topic-oriented programs offered through and by most university medical centers, presented at their own institutions. The magnitude of this effort is amply illustrated by a three-month count in my own office: more than 90 circulars were received from all manner of medical institutions, advertising professional meetings in some portion of the state, nation or world. Most assuredly, these programs present useful information, but to the degree that they are prearranged topic-centered lectures, they are inferior to *problem-oriented* community hospital based CME programs for the actual delivery of *utilizable,* retained or recallable medical information.

In California, organized medicine has manifested some concern with these local programs through its CME inspecting teams which periodically survey community hospitals for category and accreditation. But the attention devoted by the California Medical Association (CMA) to local problems in CME goal definition, organization, resource availability and program implementation has been small indeed, with the result that the local programs commonly languish, appearing better on paper than they actually are. Both the CMA and the educational medical centers might be of great value to community centers in California by assuming more leadership in the discussion of projects such as the following:

- Arrange workshop meetings with local CME directors for reviews of community CME financing, needs determination and program implementation.
- Provide an organizational format which would permit the university medical educational center to receive from participating community hospitals requests for an informational program

based on a specific perceived need, tape a program designed to deal with this need (video taping of a didactic lecture) and return it to the community hospital for its use. Should the need prove to be common to several participating community hospitals, the tape might be kept on file for a limited time for further circulation.

- Continue to offer faculty lecturers upon request as is now widely done.

The availability of educational resources in the medical educational community on one hand, matched against the evident need for improvement in CME activities in the local medical practice community on the other, provides us with an opportunity for mutual reciprocal benefit, since the educational community could sell services while the private practice community could improve its CME programs by purchasing these services.

I submit that, to date, we have paid only lip service to community hospital based CME programs. However, with the increasing emphasis on continuing medical education, a reaffirmation of interest at all levels coupled with a concrete action plan for this type of physician education is appropriate, desirable and urgently needed.

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## Cigarette Smoking and Drug Metabolism

ONE OF THE THINGS that we measure among many others in all these patients is smoking; we get a smoking history on everybody, and we look at the relationship of smoking to drug effects. . . . It turns out that smokers do apparently induce certain liver microsomal enzymes that metabolize drugs; and therefore in smokers certain drugs are metabolized more rapidly and their effect is less. We do measure efficacy on all these patients for all the drugs and we get a rate of ineffectiveness. This is simply where the physician taking care of the patient decided that the drug was ineffective. The ineffectiveness rate of propoxyphene (Darvon) is twice as high in heavy smokers as it is in nonsmokers. This goes along with metabolic data in the literature which show that the blood level of pentazocine (Talwin), a very closely similar drug, is very much lower in smokers than it is in nonsmokers. We believe that this result is probably valid and that it represents increased metabolism of this drug by people who smoke. We actually found a good half dozen drugs that affect smokers quite differently than nonsmokers, and this includes the benzodiazepines. We have rates of toxicity to diazepam (Valium), chlordiazepoxide (Librium) and phenobarbital according to smoking status, and nonsmokers have a rate of around 8 percent, heavy smokers 3 percent; for Librium, 10 percent versus 4 percent. This situation does not hold true, however, for phenobarbital; smoking does not appear to play a role in its clinical effect. But it is quite clear from these data that in smokers there is less of a clinical effect from Librium and Valium than in nonsmokers.

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